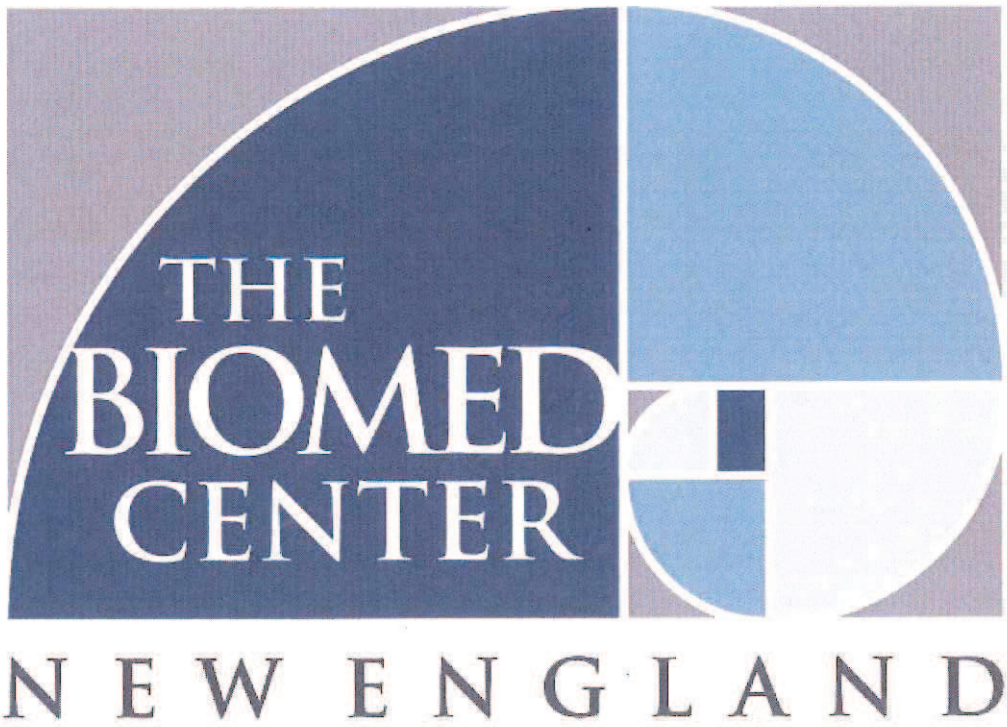
OACF | Conditions of Licensing Approval



Condition #6:
The applicant shall submit the titles and duties of all employees, as well as training, credential to RIDOH and must update RIDOH upon new hires for up to three (3) years at the discretion of RIDOH.

Condition #7:
The applicant shall submit a plan of supervision for all employees and clearly state which licensed professionals provide direct supervision (i.e. in-person, co-located with the person doing the procedure) as well as a list of procedures done with indirect supervision (i.e. licensed health care practitioner is not present in the building) to RIDOH for up to three (3) years at the discretion of RIDOH.

Condition #8:
The applicant shall establish a mechanism to, with patients' permission, coordinate care with all patients' primary care providers and other specialty providers, including reporting of consultation and treatment.

10/29/2018

NAME	TITLE	DUTIES	CREDENTIALS	LICENSE #
Administrative Director	Michael Baldwin	General oversight	N/A	N/A
Medical Director Dr. Tallman-Ruhm	Dr. Heather Tallman-Ruhm	Monitor quality and appropriateness of medical care, serve as medicalleadership representatives at standing medical staff meetings and on designated committees, oversee clinical peer review, develop and approve policies.	Medical Doctor	MD16440
Owner/Medical Consult	Dr. Jeoff Drobot	Consultations	Doctor of Naturopathy	pending
Physical Therapist	Dr. Gerald Curatola	Dental director and provider of dental services	DDS	CDEN03366
Doctor of Chiropractic Care	Dr. Jessica Daniels	Provide patient care and oversee activities of the lower level of the BioMed Center	DC	DCP00663
Medical Doctor	Dr. Yujin Nah	Provide direct patient care and services	MD	MD13398
Chief Operating Officer	Juliana Rowland	Manage dental services, administrative services, and general operations of the Center		
Nurse Manager	Patricia Jew	Oversight of IV therapies and nursing staff	Registered Nurse	RI# RN50732
Nursing Supervisor	Lori Daly	Clinical Specialist/Supervision of Nursing Staff	Registered Nurse	RI# RN61038 ACLS 9/2019 CPR 3/2019
Nurse	Lauren Slater	Staff RN/Clinical Specialist	Registered Nurse	RI# RN49854
Nurse	Angela McDonald	Staff RN/Ozone Therapies	Registered Nurse	RI# RN61089
Nurse	Nicole Fortes Williams	Phlebotomy/Autism Counselling	Licenced Practical Nurse	RI# LPN11494
Nurse - Health Coach, massage therapist, reflexologist	Julie Carter	RN Health Coach/Massage Therapist/Reflexologist	Registered Nurse	RI# RN61371 Reflexologist, LMT
Nurse	Kristi Courtney	Staff RN Thermometry	Registered Nurse	RI# RN61035
Medical Ast./Receptionist	Elizabeth Carvalho	Medical Assistant, receptionist, some office management	Medical Assistant	TBD
Reception	Sophie Emelita	Reception, coordination of modalities	Medical Administrative Assistant	N/A
Scheduling	Darla Gardener	Booking of appointments	N/A	
Registered Dental Hygienist	TBD	Provide dental hygiene services	RDH	TBD
Dental Assistant	TBD	Assist the dentist in providing dental care	CDA	TBD
Patient Advocate	Theresa F. Lynch	Provide patient support from first call throughout their care.	Registered Nurse	RI# RN54151
Patient Advocate	Cara Mia Barry	Provide patient support from first call throughout their care.	Registered Nurse	RI# RN51211

The applicant shall submit a plan of supervision for all employees and clearly state which licensed professionals provide direct supervision (i.e. in-person, co-located with the person doing the procedure) as well as a list of procedures done with indirect supervision (i.e. licensed health care practitioner is not present in the building) to RIDOH for up to three (3) years at the discretion of RIDOH.

Procedure	**Administered By (Staff Title)**	**License Required**	**Direct Supervision Required**	**Supervisor**
IV Therapy	Registered Nurse	All nurses have undergone IV	With LPN administration	Dr. Healther Tallman Ruhm to be
	Procedure: IV Nutrient Infusions	training and certification		on location during all IV infusions
	Administered by: Licensed RN/LPN under the MD Direction	Lead RN Patricia Jew and Lori		
	Patricia Jew RN	Daly have undergone advanced		
	Loreen Daly RN	training and certification		
	Kristi Courtney RN			
	Angela MacDonald RN			
	Julie Carter RN			
	Lauren Slater RN			
	Nicole Williams LPN Yes Patricia Jew RN			
Chiropractic Adjustments	Dr. Jessica Daniels	Chiropractic Physician		
Dental Services	Dr. Gerald Curatola	DDS	N/A	N/A
Dental Hygiene Services	Registered Hygienist (pending hire)	RDH	yes	Dr. Gerald Curatola
Dental Assisting Services	Certified Dental Assistant (pending hire)	CDA/RDA	yes	Dr. Gerald Curatola
Dental Imaging	RDH/CDA	RDH/CDA	yes	Dr. Gerald Curatola

TITLE 23
Health and Safety

CHAPTER 23-74
Unlicensed Health Care Practices

SECTION 23-74-1

§ 23-74-1. Definitions and applicability.

(a) As used in this chapter, the following terms have the following meanings:

(1) "Director" or "director of health" means the director of the department of health or the director's designee;

(2) "Unlicensed health care client" means an individual who receives services from an unlicensed health care practitioner;

(3) "Unlicensed health care practices" means the broad domain of unlicensed healing methods and treatments, including, but not limited to: (i) acupressure; (ii) Alexander technique; (iii) aroma therapy; (iv) ayurveda; (v) cranial sacral therapy; (vi) crystal therapy; (vii) detoxification practices and therapies; (viii) energetic healing; (ix) rolfing; (x) Gerson therapy and colostrum therapy; (xi) therapeutic touch; (xii) herbology or herbalism; (xiii) polarity therapy; (xiv) homeopathy; (xv) nondiagnostic iridology; (xvi) body work; (xvii) reiki; (xviii) mind-body healing practices; (ixx) naturopathy; and (xx) Qi Gong energy healing. "Unlicensed health care practices" do not include surgery, x-ray radiation, prescribing, administering, or dispensing legend drugs and controlled substances, practices that invade the human body by puncture of the skin, setting fractures, any practice included in the practice of dentistry, the manipulation or adjustment of articulations of joints, or the spine, also known as chiropractic medicine as defined in chapter 30 of title 5, the healing art of acupuncture as defined in chapter 37.2 of title 5, or practices that are permitted under § 5-37-15 or § 5-34-31(6).

(4) "Unlicensed health care practitioner" means a person who:

(i) Is not licensed by a health-related licensing board or the director of health; or holds a license issued by a health-related licensing board or the department of health in this state, but does not hold oneself out to the public as being licensed or registered by the director or a health-related licensing board when engaging in unlicensed health care;

(ii) Has not had a license issued by a health-related licensing board or the director of health revoked or suspended without reinstatement unless the right to engage in unlicensed health care practices has been established by order of the director of health;

(iii) Is engaging in unlicensed health care practices; and

(iv) Is providing unlicensed health care services for remuneration or is holding oneself out to the public as a practitioner of unlicensed health care practices.

(b) This chapter does not apply to, control, prevent, or restrict the practice, service, or activity of lawfully marketing or distributing food products, including dietary supplements as defined in the federal Dietary Supplement Health and Education Act [see 21 U.S.C. § 321(ff)], educating customers about those products, or explaining the uses of those products. Under Rhode Island law, an unlicensed health care practitioner may not provide a medical diagnosis.

(c) A health care practitioner, licensed or registered by the director or a health-related licensing board, who engages in unlicensed health care while practicing under the practitioner's license or registration, shall be regulated by and be under the jurisdiction of the applicable health-related licensing board with regard to the unlicensed health care practices.

(d) Subject to the provisions of this chapter, persons in Rhode Island are authorized to practice as unlicensed health care practitioners and receive remuneration for their services.

History of Section.
(P.L. 2002, ch. 133, § 1.)

Condition #8
Patients will be given the opportunity, during their initial intake process, to provide permission to coordinate care with their primary care providers and other specialty providers, to allow reporting of consultation and treatment. Below is a letter of explanation to those whose collaboration has been requested:

Dear ***{Dr. or other PCP or specialty provider's name and prefix}***,

We are grateful for the opportunity to provide support to your patient, ***{patient's full name and DOB}***, who is seeking a whole body approach to ***{his/her}*** self-care and has granted the staff at the Biomed Center NE permission to collaborate with you in this process. The American Center for Bioregulatory Medicine and Dentistry New England (Biomed Center NE) established in Providence, RI in November 2018, offers non-invasive health assessments that gives insight into disregulation of a vast network of biological systems within the body (including clues to the disregulation of the immune and cardiovascular systems, inflammation, neurovascular integrity, and organ functions).

As part of the initial intake process at the Biomed Center NE, we assign a personal patient advocate. We also ask that patients who would like to have their care coordinated with primary care providers and/or other health care specialists sign a written consent and provide contact information for all health care providers they wish to be included. Completion of signed consent as well as authorization for release of records will be collected at initial intake and will give us permission to share consultation reports and share key assessment measurements or relevant treatment plans.

Explanation of assessment outcomes and/or therapeutic services:
{insert pertinent patient information}

For more information on bioregulatory medicine, we recommend the following primer *Bioregulatory Medicine: An Integrative Holistic Approach to Self-Healing*. For more information on the Biomed Center NE, please visit https://thebiomedcenterne.com. Please feel free to reach out to our patient advocates with questions or contact our providers. We look forward to on-going collaboration and thank you for your commitment to the care of ***{patient's full name}.***

Below is a sample medical release form, similar to that which will be shared with patients during intake for medical release and collaboration consent.

PERMISSION TO SHARE PATIENT HEALTH INFORMATION

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ Phone Number: ( )

Address: _____

City: _____ State: Zip:

RECIPIENT

I authorize The BioMed Center to share my health information with:

Name of Person/Entity: _____

Title (Physician, Attorney, etc.): _____ Phone Number: ( )

Street Address: _____

City: _____ State: Zip:

Purpose of Disclosure:

☐ Medical Care ☐ Insurance ☐ Legal ☐ Transferring to New Provider ☐ Other (specify): _____

HEALTH INFORMATION TO BE SHARED

Copies of my health information within the following dates: _____ **to** _____

☐ **Abstract *OR check only those documents needed:***

☐ Discharge Summary ☐ Dental Department Reports ☐

☐ Patient Notes ☐ Laboratory/Pathology Reports ☐

☐ ☐ ☐ ☐

☐ Other_____ ☐ Records from a specific provider: _____

Delivery Preference: ☐ Pickup ☐ Mail ☐ Secure Email ☐ Fax (for Medical Care purposes) - Fax Number: (_____)

SENSITIVE HEALTH INFORMATION

The following types of information <u>will be released UNLESS</u> you place your initials in the space provided:

_____ Mental health treatment records _____Sexually Transmitted Disease (STD) treatment records

_____ Genetic testing _____Alcohol/drug abuse treatment records

_____ HIV/AIDS test results

DURATION & REVOCATION

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____ (date). You or your Personal Representative may revoke this authorization at any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously released information.

ADDITIONAL INFORMATION

I understand that:

- A fee for the cost of processing this request may be charged.
- The BioMed Center will not condition my ability to receive healthcare services on providing or refusing to provide this authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
- Once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
- The BioMed Center may utilize a business associate/authorized agent to assist in fulfilling this request.

SIGNATURE

_____ _____

Signature of Patient or Personal Representative **Date**

_____ _____

Printed Name of Patient or Personal Representative **Description of Personal Representative's Authority**

INSTRUCTIONS:
How to fill out "Permission to Share Patient Health Information" authorization form

This form should be used when you want your medical and/or dental records held by The BioMed Center to be sent to a third party.

Please complete all sections. An incomplete authorization may result in a delay in processing your request.

PATIENT INFORMATION

Complete each box as indicated with the following information:

- Patient's name (please print clearly)
- Patient's Date of Birth
- Telephone number where you can be reached during the day
- Patient's Mailing Address, including City, State, and Zip Code

RECIPIENT

Tell us the individual or business entity that is to receive the information. Include:

- Recipient's Name or Business Entity's (Company's) Name
- Title of who is to receive the information. Examples: Physician, Attorney, Insurance Company, etc.
- Telephone number of the person or entity who will receive the information
- Mailing address of who will receive the information, including City, State, and Zip Code

Check the box that best describes the purpose for sharing your health information. If no box relates to your purpose, check "Other" and state the purpose for the release on the line provided. Examples: Benefits, Workers' Compensation, Personal, etc. **This section must be filled for the form to be valid.**

HEALTH INFORMATION TO BE SHARED

Fill in the date range that applies to the health information you are requesting we share.

Check the box(es) that apply to your request:

- An Abstract is a comprehensive **summary** of your healthcare information. An Abstract is **not** a complete copy of your health (medical) record maintained by The BioMed Center.
- You can tell us you want your records from only a specific provider by checking the "Records from a specific provider" box and filling in the relevant provider's name.

Please indicate delivery preference. If no options are checked, typically the records will be sent via USPS.

SENSITIVE HEALTH INFORMATION

If you do not place your initials in the space provided, we **WILL** release sensitive information contained in your medical record as necessary to fulfill your request. For more information on how we share your sensitive information, please refer to our Notice of Privacy Practices, available on our website, or contact the Privacy Office where your records are located.

DURATION & REVOCATION

Your authorization will remain valid for one year from the date of your signature, unless you specify a different date in the space provided. You have the right to revoke your permission at any time. Please revoke by following the directions in our Notice of Privacy Practices, available on our website, or call the Privacy Office where your records are located.

ADDITIONAL INFORMATION

Please read. Sometimes there is a fee for sending your records. Please call for any questions around fees.

SIGNATURE

Sign and date the authorization. Patients between the ages of 12 and 17 may be required to sign this form, depending on the type of care received.

If you are not the patient, describe your relationship and legal authority to sign. In some cases, you will be required to provide legal paperwork verifying your authority (e.g., court-appointed guardian, power of attorney for health care). For a deceased patient, a court order appointing you as the executor or administrator must accompany the form.